TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WALTER BAIN, MD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-15-4134-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reply from Texas Mutual regarding incomplete bill submitted was received and the claim was resubmitted again. Our claim form was returned in the mail stating they had not yet received a notice of injury for this patient."

Amount in Dispute: $669.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted an incomplete bill for the date of service above. Texas Mutual returned the bill to the requestor with an explanatory letter regarding failure to complete Box 7 of the CMS-1500 form. (Attachment) As of the date of this response Texas Mutual has no record of receiving a completed bill. Because Texas Mutual has not denied or reduced the bill from the requestor, no dispute exists."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2015	Professional Medical Services	$669.38	$550.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines terms related to medical billing and bill processing.
2. 28 Texas Administrative Code §133.10 sets out requirements regarding medical billing forms and formats.
3. 28 Texas Administrative Code §133.200 sets out procedures regarding insurance carrier receipt of medical bills.
4. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

6. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
7. Neither party to this dispute presented copies of any explanations of benefits or other documentation supporting insurance carrier payment or denial of the disputed services. No information regarding claim adjustment codes or payment denial reasons for the disputed services was presented for review.

Issues

1. Did the insurance carrier properly return the health care provider's first medical bill?
2. Did the insurance carrier properly return the health care provider's second medical bill submission?
3. Did the insurance carrier waive the right to deny or raise defenses to payment for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute involves the insurance carrier's return of a medical bill without a payment or denial of the disputed services. The respondent states:

   > The requestor submitted an incomplete bill for the date of service above. Texas Mutual returned the bill to the requestor with an explanatory letter regarding failure to complete Box 7 of the CMS-1500 form. (Attachment) As of the date of this response Texas Mutual has no record of receiving a completed bill. Because Texas Mutual has not denied or reduced the bill from the requestor, no dispute exists.

   The insurance carrier returned the health care provider's initial bill submission as an incomplete bill, in accordance with 28 Texas Administrative Code §133.200(a)(2)(B) which requires that, after reviewing the bill for completeness, within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall return the bill to the sender, in accordance with §133.200(c).

   28 Texas Administrative Code §133.2 (4) defines a complete medical bill as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats)."

   28 Texas Administrative Code §133.10(f)(1)(G) requires the "employer's address (CMS-1500, field 7)" be completed in the field number corresponding to the medical billing form for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care.

   Rule §133.200(c) states, "The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill."

   Review of the submitted information finds that field 7, "INSURED'S ADDRESS," was left blank on the provider's initial medical bill submission. The insurance carrier met the requirements for the proper return of a medical bill in accordance with §133.200(c) with regard to the return of an incomplete bill.

2. The health care provider presented documentation to support submission to the insurance carrier of a second medical bill with the missing information completed per the insurance carrier instructions. The provider further presented documentation to support that the second medical bill was received by the insurance carrier and returned a second time with a letter dated July 14, 2015, stating, "The Texas Mutual Insurance Company has not yet received a notice of injury for the above-referenced employee. Your correspondence does not include information necessary to be considered a First Notice of Injury as defined in the DWC Rule 124.1," with additional comment: "Please provide the address of the employer."

   Review of field 7 (employer's address) on the provider's second bill submission finds that the field has been completed in accordance with the requirements of Rule §133.10(f)(1)(G).

   Rule §133.200(b) requires that "An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item."

Rule §133.200(a)(1) states that "Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill."

Review of the submitted information finds that the insurance carrier has not met the requirements of §133.200(a)(1) and (b) with regard to the return of the provider's second bill submission.

3. 28 Texas Administrative Code §133.240(a) provides that:

> An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

Rule §133.240(e)(1) requires the insurance carrier to send an explanation of benefits (EOB) to "the health care provider when the insurance carrier makes payment or denies payment on a medical bill."

Rule §133.240(f)(17)(G) requires the EOB to contain for each billed service an adjustment reason code if total amount paid does not equal total amount charged.

Rule §133.240(f)(17)(G) requires the EOB to contain for each billed service an explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G).

28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The respondent did not present documentation to support taking final action after conducting bill review within 45 days from receipt of the provider's complete medical bill submission. The respondent did not present copies of any EOBs or documentation of any adjustment reason codes for each billed service. The respondent did not present documentation of any explanation of the reasons for reduction or denial of the services in dispute. The respondent has not submitted any information to support that it has presented to the requestor any denial reasons regarding the services in dispute prior to the date the request for MFDR was filed. Consequently, pursuant to Rule §133.307(d)(2)(F) , the respondent has waived the right to raise any denial reasons or defenses with respect to the services in this dispute. Any such newly raised denial reasons or defenses shall not be considered in this review. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

4. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

> To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is $56.20. Reimbursement is calculated as follows:

- Procedure code 99203, service date May 21, 2015, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.42. The practice expense (PE) RVU of 1.48 multiplied by the PE GPCI of 0.92 is 1.3616. The malpractice RVU of 0.15 multiplied by the malpractice GPCI of 0.822 is 0.1233. The sum of 2.9049 is multiplied by the Division conversion factor of $56.20 for a MAR of $163.26.

- Procedure code 69210, service date May 21, 2015, the relative value (RVU) for work of 0.61 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.61. The practice expense (PE) RVU of 0.72 multiplied by the PE GPCI of 0.92 is 0.6624. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.822 is 0.05754. The sum of 1.32994 is multiplied by the Division conversion factor of $56.20 for a MAR of $74.74.
- Procedure code 31231, service date May 21, 2015, the relative value (RVU) for work of 1.1 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.1. The practice expense (PE) RVU of 4.71 multiplied by the PE GPCI of 0.92 is 4.3332. The malpractice RVU of 0.16 multiplied by the malpractice GPCI of 0.822 is 0.13152. The sum of 5.56472 is multiplied by the Division conversion factor of $56.20 for a MAR of $312.74.

The total allowable reimbursement for the services in dispute is $550.74. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $550.74. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $550.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $550.74 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 19, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.